

8029

CERTIFICATE OF DEATH

Reg. Dist. No.

08012

1. PLACE OF DEATH a. COUNTY <u>Howard</u> MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Baltimore</u>			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Ellicott City</u>				c. LENGTH OF STAY IN 1b <u>7 days</u>			
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>Taylor Manor Hospital</u>				d. STREET ADDRESS <u>4938 Hazel Ave.</u>			
3. NAME OF DECEASED (Type or print) First <u>Charles</u> Middle <u>Philip</u> Last <u>Damast Sr.</u>				4. DATE OF DEATH Month <u>July</u> Day <u>28</u> Year <u>19 59</u>			
5. SEX <u>Male</u>		6. COLOR OR RACE <u>white</u>		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH <u>12/21/16</u>	
9. AGE (In years last birthday) <u>42</u> yrs.		IF UNDER 1 YEAR Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>		IF UNDER 24 HRS. Months <u> </u> Days <u> </u> Hours <u> </u> Min. <u> </u>			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>stationary engineer</u>				10b. KIND OF BUSINESS OR INDUSTRY <u>Calvert Distill.</u>		11. BIRTHPLACE (State or foreign country) <u>Baltimore, Md.</u>	
12. CITIZEN OF WHAT COUNTRY? <u>U.S.</u>							
13. FATHER'S NAME <u>FRED. W. DAMAST</u>				14. MOTHER'S MAIDEN NAME <u>MADELINE COOK</u>			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>NO</u>				16. SOCIAL SECURITY NO. <u> </u>		17. INFORMANT <u>Mrs. Chas P. Damast Sr.</u> Address <u>4938 Hazel Ave</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>Medullary Brain-stem damage</u> <u>322.2</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last: (b) <u>Acute Brain Syndrome due to alcoholism</u> DUE TO (c) <u> </u>							INTERVAL BETWEEN ONSET AND DEATH <u>5 days</u> <u>7 days</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>Pneumonia</u>							19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour a. m. <u> </u> p. m. <u> </u> 19 <u>59</u>				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u> </u>	
20f. (City or town) <u> </u>				20g. (County) <u> </u>		20h. (State) <u> </u>	
21. I certify that I attended the deceased from <u>July 21</u> , 19 <u>59</u> , to <u>July 28</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>July 28</u> , 19 <u>59</u> , and that death occurred at <u>1460</u> a.m., from the causes and on the date stated above.							
ACTUAL SIGNATURE <u>Irving J. Taylor</u> M.D.				ADDRESS (Street, city or town, state) <u>Taylor Manor Hospital</u>			
DATE SIGNED <u> </u>							
PHYSICIAN'S NAME (Type) <u>Irving J. Taylor, M.D., Taylor Manor Hospital, Ellicott City, Md.</u>							
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>Buried</u>		22b. DATE THEREOF <u>7-31-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>London Park Cem.</u>		22d. LOCATION (City, town, or county) (State) <u>Balls Blad</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>Forley Funeral Home-Catonoville, Md</u>				ADDRESS <u> </u>		24a. REC'D BY REGISTRAR DATE <u>AUG 3 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur L. Kirsch</u>							

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital for the attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8030

CERTIFICATE OF DEATH

Reg. Dist. No.

08013

1. PLACE OF DEATH a. COUNTY H oward			b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Brookeville., (Rural)			c. LENGTH OF STAY IN 1b Life			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland			b. COUNTY Howard											
3. NAME OF DECEASED (Type or print) First CARRIE			Middle LEE			Last ESTEP			4. DATE OF DEATH Month July			Day 28,			Year 19 59								
5. SEX Female			6. COLOR OR RACE Colored			7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>			8. DATE OF BIRTH Jan. 27, 1884			9. AGE (In years last birthday) 75 yrs.			IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.								
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Domestic						10b. KIND OF BUSINESS OR INDUSTRY						11. BIRTHPLACE (State or foreign country) Maryland						12. CITIZEN OF WHAT COUNTRY? U. S. A.					
13. FATHER'S NAME Jesse Wise									14. MOTHER'S MAIDEN NAME Mary Green														
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)						16. SOCIAL SECURITY NO.						17. INFORMANT Address Leroy Estep. Silver Spring, Md. Route # 1											
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cerebrovascular accident 331x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) _____ DUE TO (c) _____															INTERVAL BETWEEN ONSET AND DEATH 4 hours								
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)																		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)																		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)					
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19						20d. INJURY OCCURRED While of work <input type="checkbox"/> Not while of work <input type="checkbox"/>			20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)			20f. (City or town) (County) (State)											
21. I certify that I attended the deceased from July 12 , 19 59 , to July 28 , 19 59 , that I last saw the deceased alive on July 28 , 19 59 , and that death occurred on 10:00 P. M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED Clarksville, Maryland 7-28-59																							
ACTUAL SIGNATURE Charles S. Whitaker, M.D.																							
PHYSICIAN'S NAME (Type) Charles S. Whitaker, M.D.																							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial						22b. DATE THEREOF 8/2/59			22c. NAME OF CEMETERY OR CREMATORY Hopkins Chapel,						22d. LOCATION (City, town, or county) (State) Highland, Md.								
23. FUNERAL DIRECTOR'S SIGNATURE Robert L. Surdick									ADDRESS Brookeville, Md.									24a. REC'D BY REGISTRAR DATE AUG 5 59			24b. REGISTRAR'S SIGNATURE Arthur S. Hines		

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filled with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8031

CERTIFICATE OF DEATH

08014

Reg. Dist. No.

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Md. b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION St. John's Lane		d. STREET ADDRESS St. John's Lane	
3. NAME OF DECEASED (Type or print) First Harry Middle E. Last Foster		4. DATE OF DEATH Month July Day 20 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH 12-6-1892
9. AGE (In years last birthday) 66 yrs.		10. IF UNDER 1 YEAR: Months 6 Days 6 Hours 19 Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Farmer		10b. KIND OF BUSINESS OR INDUSTRY ****	
11. BIRTHPLACE (State or foreign country) Virginia		12. CITIZEN OF WHAT COUNTRY? U.S.A.	
13. FATHER'S NAME Walter Foster		14. MOTHER'S MAIDEN NAME Sarah Louise Hundley	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service) No		16. SOCIAL SECURITY NO. 223-18-7803	
17. INFORMANT Mrs. Millard T. Traband Jr. (Same as above())		Address	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Arteriosclerotic cardiovascular disease DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 6 hours 10 years			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) 19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER) *****		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.) *****	
20c. TIME OF INJURY Month, Day, Year Hour ***** Min. *****		20d. INJURY OCCURRED While <input checked="" type="checkbox"/> at work <input type="checkbox"/> Not while <input type="checkbox"/> at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) *****		20f. (City or town) (County) (State) *****	
21. I certify that I attended the deceased from 19 50 to July 19 59 , that I last saw the deceased alive on 20 July 19 59 , and that death occurred at 6:00 PM , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 5101 Gwynn Oak Avenue, Baltimore, 7, Maryland DATE SIGNED 7/20/59 ACTUAL SIGNATURE Millard T. Traband Jr. M.D. PHYSICIAN'S NAME (Type) Millard T. Traband, Jr. M. D.			
22a. BURIAL, CREMATION, REMOVAL (Specify) Removal		22b. DATE THEREOF 7-21-59	
22c. NAME OF CEMETERY OR CREMATORY Trinity		22d. LOCATION (City, town, or county) (State) Foster, Virginia.	
23. FUNERAL DIRECTOR'S SIGNATURE Wm. J. Tucker		24a. REC'D BY REGISTRAR Jul 21 1959 DATE July 20, 1959	

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1951-1952 1953-1954 1955-1956 1957-1958 1959-1960 1961-1962 1963-1964 1965-1966 1967-1968 1969-1970 1971-1972 1973-1974 1975-1976 1977-1978 1979-1980 1981-1982 1983-1984 1985-1986 1987-1988 1989-1990 1991-1992 1993-1994 1995-1996 1997-1998 1999-2000 2001-2002 2003-2004 2005-2006 2007-2008 2009-2010 2011-2012 2013-2014 2015-2016 2017-2018 2019-2020 2021-2022 2023-2024 2025-2026 2027-2028 2029-2030 2031-2032 2033-2034 2035-2036 2037-2038 2039-2040 2041-2042 2043-2044 2045-2046 2047-2048 2049-2050 2051-2052 2053-2054 2055-2056 2057-2058 2059-2060 2061-2062 2063-2064 2065-2066 2067-2068 2069-2070 2071-2072 2073-2074 2075-2076 2077-2078 2079-2080 2081-2082 2083-2084 2085-2086 2087-2088 2089-2090 2091-2092 2093-2094 2095-2096 2097-2098 2099-2100 2101-2102 2103-2104 2105-2106 2107-2108 2109-2110 2111-2112 2113-2114 2115-2116 2117-2118 2119-2120 2121-2122 2123-2124 2125-2126 2127-2128 2129-2130 2131-2132 2133-2134 2135-2136 2137-2138 2139-2140 2141-2142 2143-2144 2145-2146 2147-2148 2149-2150 2151-2152 2153-2154 2155-2156 2157-2158 2159-2160 2161-2162 2163-2164 2165-2166 2167-2168 2169-2170 2171-2172 2173-2174 2175-2176 2177-2178 2179-2180 2181-2182 2183-2184 2185-2186 2187-2188 2189-2190 2191-2192 2193-2194 2195-2196 2197-2198 2199-2200 2201-2202 2203-2204 2205-2206 2207-2208 2209-2210 2211-2212 2213-2214 2215-2216 2217-2218 2219-2220 2221-2222 2223-2224 2225-2226 2227-2228 2229-2230 2231-2232 2233-2234 2235-2236 2237-2238 2239-2240 2241-2242 2243-2244 2245-2246 2247-2248 2249-2250 2251-2252 2253-2254 2255-2256 2257-2258 2259-2260 2261-2262 2263-2264 2265-2266 2267-2268 2269-2270 2271-2272 2273-2274 2275-2276 2277-2278 2279-2280 2281-2282 2283-2284 2285-2286 2287-2288 2289-2290 2291-2292 2293-2294 2295-2296 2297-2298 2299-2300 2301-2302 2303-2304 2305-2306 2307-2308 2309-2310 2311-2312 2313-2314 2315-2316 2317-2318 2319-2320 2321-2322 2323-2324 2325-2326 2327-2328 2329-2330 2331-2332 2333-2334 2335-2336 2337-2338 2339-2340 2341-2342 2343-2344 2345-2346 2347-2348 2349-2350 2351-2352 2353-2354 2355-2356 2357-2358 2359-2360 2361-2362 2363-2364 2365-2366 2367-2368 2369-2370 2371-2372 2373-2374 2375-2376 2377-2378 2379-2380 2381-2382 2383-2384 2385-2386 2387-2388 2389-2390 2391-2392 2393-2394 2395-2396 2397-2398 2399-2400 2401-2402 2403-2404 2405-2406 2407-2408 2409-2410 2411-2412 2413-2414 2415-2416 2417-2418 2419-2420 2421-2422 2423-2424 2425-2426 2427-2428 2429-2430 2431-2432 2433-2434 2435-2436 2437-2438 2439-2440 2441-2442 2443-2444 2445-2446 2447-2448 2449-2450 2451-2452 2453-2454 2455-2456 2457-2458 2459-2460 2461-2462 2463-2464 2465-2466 2467-2468 2469-2470 2471-2472 2473-2474 2475-2476 2477-2478 2479-2480 2481-2482 2483-2484 2485-2486 2487-2488 2489-2490 2491-2492 2493-2494 2495-2496 2497-2498 2499-2500 2501-2502 2503-2504 2505-2506 2507-2508 2509-2510 2511-2512 2513-2514 2515-2516 2517-2518 2519-2520 2521-2522 2523-2524 2525-2526 2527-2528 2529-2530 2531-2532 2533-2534 2535-2536 2537-2538 2539-2540 2541-2542 2543-2544 2545-2546 2547-2548 2549-2550 2551-2552 2553-2554 2555-2556 2557-2558 2559-2560 2561-2562 2563-2564 2565-2566 2567-2568 2569-2570 2571-2572 2573-2574 2575-2576 2577-2578 2579-2580 2581-2582 2583-2584 2585-2586 2587-2588 2589-2590 2591-2592 2593-2594 2595-2596 2597-2598 2599-2600 2601-2602 2603-2604 2605-2606 2607-2608 2609-2610 2611-2612 2613-2614 2615-2616 2617-2618 2619-2620 2621-2622 2623-2624 2625-2626 2627-2628 2629-2630 2631-2632 2633-2634 2635-2636 2637-2638 2639-2640 2641-2642 2643-2644 2645-2646 2647-2648 2649-2650 2651-2652 2653-2654 2655-2656 2657-2658 2659-2660 2661-2662 2663-2664 2665-2666 2667-2668 2669-2670 2671-2672 2673-2674 2675-2676 2677-2678 2679-2680 2681-2682 2683-2684 2685-2686 2687-2688 2689-2690 2691-2692 2693-2694 2695-2696 2697-2698 2699-2700 2701-2702 2703-2704 2705-2706 2707-2708 2709-2710 2711-2712 2713-2714 2715-2716 2717-2718 2719-2720 2721-2722 2723-2724 2725-2726 2727-2728 2729-2730 2731-2732 2733-2734 2735-2736 2737-2738 2739-2740 2741-2742 2743-2744 2745-2746 2747-2748 2749-2750 2751-2752 2753-2754 2755-2756 2757-2758 2759-2760 2761-2762 2763-2764 2765-2766 2767-2768 2769

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TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

8032

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

Gieske, Elsie CERTIFICATE OF DEATH

Reg. Dist. No.

08015

1. PLACE OF DEATH o. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Rural Woodbine		c. LENGTH OF STAY IN 1b 6 yrs.	
c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) X(Rural) Woodbine		d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Florence Road	
e. IS RESIDENCE ON A FARM? YES <input checked="" type="checkbox"/> NO <input type="checkbox"/>		f. STREET ADDRESS Florence Road	
3. NAME OF DECEASED (Type or print) First ELSIE Middle EDITH Last GIESKE		4. DATE OF DEATH Month July Day 24th. Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input checked="" type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH June 26, 1876
9. AGE (In years lost birthday) yrs. 83		IF UNDER 1 YEAR IF UNDER 24 HRS. Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Housewife		10b. KIND OF BUSINESS OR INDUSTRY Own home	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME George Franke		14. MOTHER'S MAIDEN NAME Mary L. Hamm	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. None	
17. INFORMANT A. W. Gieske Jr.		Address Florence Rd. Woodbine, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Senility 289.2 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Collagen vascular disease, probably, etiology uncertain. DUE TO (c) PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) INTERVAL BETWEEN ONSET AND DEATH 2 years several years		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from 2-1- , 19 54 , to 7-24- , 19 59 , that I last saw the deceased alive on 7-17- , 19 59 , and that death occurred at M. , from the causes and on the date stated above. ADDRESS (Street, city or town, state) 35 E Church Frederick Md DATE SIGNED 7-25-59			
ACTUAL SIGNATURE Rex R Martin M.D.		PHYSICIAN'S NAME (Type) Rex R Martin	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/27/59	
22c. NAME OF CEMETERY OR CREMATORY Salem Lutheran		22d. LOCATION (City, town, or county) (State) Catonsville, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Custord Sons		24a. REC'D BY REGISTRAR Arthur S. Hanna	
ADDRESS Catonsville Md		24b. REGISTRAR'S SIGNATURE Arthur S. Hanna	
DATE JUL 30 '59			

BALTIMORE STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8033

CERTIFICATE OF DEATH

Reg. Dist. No.

08016

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Jessup	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION Jessup Road		d. STREET ADDRESS Jessups Road	
3. NAME OF DECEASED (Type or print) First Oscar Middle Wilbert Last Hammond		4. DATE OF DEATH Month July Day 7 Year 19 59	
5. SEX Male	6. COLOR OR RACE Colored	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH April 23, 1905
9. AGE (In years last birthday) 54 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	IF UNDER 24 HRS.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer		10b. KIND OF BUSINESS OR INDUSTRY	11. BIRTHPLACE (State or foreign country) Maryland
12. CITIZEN OF WHAT COUNTRY? U.S.A.		13. FATHER'S NAME James Edward Hammond	
14. MOTHER'S MAIDEN NAME Annie E. Johnson		15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) (If yes, give war or dates of service)	
16. SOCIAL SECURITY NO.		17. INFORMANT Mrs. Ella Hammond Jessups Road.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary Occlusion 260x DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) Diabetes Mellitus DUE TO (c) INTERVAL BETWEEN ONSET AND DEATH 5 years			19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input type="checkbox"/>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Hour a. m. p. m. Month, Day, Year 19	20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)	20f. (City or town) (County) (State)
21. I certify that I attended the deceased from 6.25 , 19 59 , to 7.7 , 19 59 , that I last saw the deceased alive on 7-6 , 19 59 , and that death occurred at 7:30 M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) 825 N. Fremont Ave DATE SIGNED ACTUAL SIGNATURE H. P. Hughes M.D. PHYSICIAN'S NAME (Type)			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial	22b. DATE THEREOF 7-11-59	22c. NAME OF CEMETERY OR CREMATORY Mt. Auburn Cem	22d. LOCATION (City, town, or county) (State) Baltimore, Md.
23. FUNERAL DIRECTOR'S SIGNATURE Mr. Francis A. Humphrey		24a. REC'D BY REGISTRAR JUL 13 '59	24b. REGISTRAR'S SIGNATURE Clinton S. Kraus

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital. The attending physician and completely filled in by the funeral director. TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8034 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No.

08017

1. PLACE OF DEATH a. COUNTY Howard MARYLAND b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Dayton c. LENGTH OF STAY IN lb 4 hours d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Howard Road				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY <input checked="" type="checkbox"/> c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Baltimore 3Y01-4 d. STREET ADDRESS 2118 N. Pulaski Street e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>											
3. NAME OF DECEASED (Type or print) First Lewis Middle Winfield Last Johnson				4. DATE OF DEATH Month July Day 27 Year 1959											
5. SEX Male		6. COLOR OR RACE Col		7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Dedember 17, '93		9. AGE (In years last birthday) 65 yrs.		IF UNDER 1 YEAR Months 65 Days 65		IF UNDER 24 HRS. Hours 65 Min. 65			
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Laborer				10b. KIND OF BUSINESS OR INDUSTRY Cemetary				11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? U.S.A.			
13. FATHER'S NAME John E. Johnson						14. MOTHER'S MAIDEN NAME Fanny Burgess									
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (If yes, give war or dates of service) yes <input checked="" type="checkbox"/> WW I				16. SOCIAL SECURITY NO. 219109175		17. INFORMANT Address Frances Johnson, 2118 N. Pulaski, Balto.									
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Acute cardiac failure DUE TO Conditions, if any, which gave rise to immediate cause (b) Coronary artery occlusion (a), stating the underlying cause last. DUE TO (c)												INTERVAL BETWEEN ONSET AND DEATH. instant. instant.			
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)														19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Port II of item 18.)											
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19				20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)							
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/>, Inspection <input checked="" type="checkbox"/>, Inquiry <input checked="" type="checkbox"/>, and find that death resulted from: Natural causes <input checked="" type="checkbox"/>, Accident <input type="checkbox"/>, Suicide <input type="checkbox"/>, Homicide <input type="checkbox"/>, Undetermined cause <input type="checkbox"/>.															
ACTUAL SIGNATURE <i>Charles S. Whitaker, M.D.</i>				CHIEF MEDICAL EXAMINER <input type="checkbox"/>				DATE SIGNED							
EXAMINER'S NAME (Type) Charles S. Whitaker, M.D.				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>				7-27-59							
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial				22b. DATE THEREOF 7-30-59		22c. NAME OF CEMETERY OR CREMATORY Balto Nat				22d. LOCATION (City, town, or county) (State) Balto Md					
23. FUNERAL DIRECTOR'S SIGNATURE <i>Geo. S. Nelson</i>						ADDRESS 1348 W. Calhoun		24a. REC'D BY REGISTRAR DATE JUL 30 '59		24b. REGISTRAR'S SIGNATURE <i>Arthur L. Hines</i>					

TO DEPUTY MEDICAL EXAMINER: If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM3. Page 5 may be retained for your files. File pages 1 and 2 with the registrar to burial, cremation, or removal.

803 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

KANSAS STATE DEPARTMENT OF HEALTH - BUREAU OF VITAL STATISTICS

00017

<p>1. NAME OF DECEASED</p>		<p>2. SEX</p>	
<p>3. AGE</p>		<p>4. DATE OF BIRTH</p>	
<p>5. PLACE OF BIRTH</p>		<p>6. OCCUPATION</p>	
<p>7. MARITAL STATUS</p>		<p>8. COLOR</p>	
<p>9. EDUCATION</p>		<p>10. RELIGION</p>	
<p>11. PRESENT ADDRESS</p>		<p>12. DATE OF DEATH</p>	
<p>13. TIME OF DEATH</p>		<p>14. PLACE OF DEATH</p>	
<p>15. CAUSE OF DEATH</p>		<p>16. MANNER OF DEATH</p>	
<p>17. SIGNATURE OF EXAMINER</p>		<p>18. SIGNATURE OF WITNESS</p>	
<p>19. SIGNATURE OF DECEASED</p>		<p>20. SIGNATURE OF NEXT OF KIN</p>	
<p>21. SIGNATURE OF CLERK</p>		<p>22. SIGNATURE OF JURY</p>	
<p>23. SIGNATURE OF JUDGE</p>		<p>24. SIGNATURE OF SHERIFF</p>	
<p>25. SIGNATURE OF CORONER</p>		<p>26. SIGNATURE OF DISTRICT ATTORNEY</p>	
<p>27. SIGNATURE OF COUNTY CLERK</p>		<p>28. SIGNATURE OF COUNTY SHERIFF</p>	
<p>29. SIGNATURE OF COUNTY JUDGE</p>		<p>30. SIGNATURE OF COUNTY CLERK</p>	
<p>31. SIGNATURE OF COUNTY SHERIFF</p>		<p>32. SIGNATURE OF COUNTY JUDGE</p>	
<p>33. SIGNATURE OF COUNTY CLERK</p>		<p>34. SIGNATURE OF COUNTY SHERIFF</p>	
<p>35. SIGNATURE OF COUNTY JUDGE</p>		<p>36. SIGNATURE OF COUNTY CLERK</p>	
<p>37. SIGNATURE OF COUNTY SHERIFF</p>		<p>38. SIGNATURE OF COUNTY JUDGE</p>	
<p>39. SIGNATURE OF COUNTY CLERK</p>		<p>40. SIGNATURE OF COUNTY SHERIFF</p>	
<p>41. SIGNATURE OF COUNTY JUDGE</p>		<p>42. SIGNATURE OF COUNTY CLERK</p>	
<p>43. SIGNATURE OF COUNTY SHERIFF</p>		<p>44. SIGNATURE OF COUNTY JUDGE</p>	
<p>45. SIGNATURE OF COUNTY CLERK</p>		<p>46. SIGNATURE OF COUNTY SHERIFF</p>	
<p>47. SIGNATURE OF COUNTY JUDGE</p>		<p>48. SIGNATURE OF COUNTY CLERK</p>	
<p>49. SIGNATURE OF COUNTY SHERIFF</p>		<p>50. SIGNATURE OF COUNTY JUDGE</p>	
<p>51. SIGNATURE OF COUNTY CLERK</p>		<p>52. SIGNATURE OF COUNTY SHERIFF</p>	
<p>53. SIGNATURE OF COUNTY JUDGE</p>		<p>54. SIGNATURE OF COUNTY CLERK</p>	
<p>55. SIGNATURE OF COUNTY SHERIFF</p>		<p>56. SIGNATURE OF COUNTY JUDGE</p>	
<p>57. SIGNATURE OF COUNTY CLERK</p>		<p>58. SIGNATURE OF COUNTY SHERIFF</p>	
<p>59. SIGNATURE OF COUNTY JUDGE</p>		<p>60. SIGNATURE OF COUNTY CLERK</p>	
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<p>63. SIGNATURE OF COUNTY CLERK</p>		<p>64. SIGNATURE OF COUNTY SHERIFF</p>	
<p>65. SIGNATURE OF COUNTY JUDGE</p>		<p>66. SIGNATURE OF COUNTY CLERK</p>	
<p>67. SIGNATURE OF COUNTY SHERIFF</p>		<p>68. SIGNATURE OF COUNTY JUDGE</p>	
<p>69. SIGNATURE OF COUNTY CLERK</p>		<p>70. SIGNATURE OF COUNTY SHERIFF</p>	
<p>71. SIGNATURE OF COUNTY JUDGE</p>		<p>72. SIGNATURE OF COUNTY CLERK</p>	
<p>73. SIGNATURE OF COUNTY SHERIFF</p>		<p>74. SIGNATURE OF COUNTY JUDGE</p>	
<p>75. SIGNATURE OF COUNTY CLERK</p>		<p>76. SIGNATURE OF COUNTY SHERIFF</p>	
<p>77. SIGNATURE OF COUNTY JUDGE</p>		<p>78. SIGNATURE OF COUNTY CLERK</p>	
<p>79. SIGNATURE OF COUNTY SHERIFF</p>		<p>80. SIGNATURE OF COUNTY JUDGE</p>	
<p>81. SIGNATURE OF COUNTY CLERK</p>		<p>82. SIGNATURE OF COUNTY SHERIFF</p>	
<p>83. SIGNATURE OF COUNTY JUDGE</p>		<p>84. SIGNATURE OF COUNTY CLERK</p>	
<p>85. SIGNATURE OF COUNTY SHERIFF</p>		<p>86. SIGNATURE OF COUNTY JUDGE</p>	
<p>87. SIGNATURE OF COUNTY CLERK</p>		<p>88. SIGNATURE OF COUNTY SHERIFF</p>	
<p>89. SIGNATURE OF COUNTY JUDGE</p>		<p>90. SIGNATURE OF COUNTY CLERK</p>	
<p>91. SIGNATURE OF COUNTY SHERIFF</p>		<p>92. SIGNATURE OF COUNTY JUDGE</p>	
<p>93. SIGNATURE OF COUNTY CLERK</p>		<p>94. SIGNATURE OF COUNTY SHERIFF</p>	
<p>95. SIGNATURE OF COUNTY JUDGE</p>		<p>96. SIGNATURE OF COUNTY CLERK</p>	
<p>97. SIGNATURE OF COUNTY SHERIFF</p>		<p>98. SIGNATURE OF COUNTY JUDGE</p>	
<p>99. SIGNATURE OF COUNTY CLERK</p>		<p>100. SIGNATURE OF COUNTY SHERIFF</p>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in by the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8035

CERTIFICATE OF DEATH

Reg. Dist. No.

08018

1. PLACE OF DEATH a. COUNTY Howard County MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE Ma. b. COUNTY Ellicott City	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 147 Columbia Road		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Jerome Middle A. Last Loughran, Sr.		4. DATE OF DEATH Month July Day 1 Year 1959	
5. SEX Male	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Dec. 23, 1896
9. AGE (In years lost birthday) 62 yrs.		10. IF UNDER 1 YEAR Months <input type="checkbox"/> Days <input type="checkbox"/> Hours <input type="checkbox"/> Min. <input type="checkbox"/>	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Attorney		10b. KIND OF BUSINESS OR INDUSTRY Own Business	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? USA	
13. FATHER'S NAME John J. Loughran		14. MOTHER'S MAIDEN NAME Ellen Rock	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) Yes		16. SOCIAL SECURITY NO. 212 34 8846	
17. INFORMANT Mrs. Mary T. Loughran		Address Ellicott City, Ma	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Cardiac Failure 153.8 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) — DUE TO (c) Carcinoma of Colon PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) None		INTERVAL BETWEEN ONSET AND DEATH Immediate 1 year	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from October 10, 1958 to July 1, 1959 , that I last saw the deceased alive on June 30, 1959 , and that death occurred at 11:45 A.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE William F. Tassaway		DATE SIGNED 7-1-59	
PHYSICIAN'S NAME (Type)		ADDRESS (Street, city or town, state)	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF July 4/59	
22c. NAME OF CEMETERY OR CREMATORY New Cathedral		22d. LOCATION (City, town, or county) (State) Baltimore 29 Ma	
23. FUNERAL DIRECTOR'S SIGNATURE Witzke Funeral Directors		24a. REC'D BY REGISTRAR JUL 6 '59	
ADDRESS 4101 E. Diamondson Ave		24b. REGISTRAR'S SIGNATURE Arthur S. Knecht	

CERTIFICATE OF DEATH

2027

NAME: HOWARD J. JENNY SEX: MALE RACE: WHITE

DATE OF BIRTH: 11/13/1913 PLACE OF BIRTH: WILMINGTON, DE.

DATE OF DEATH: 1/13/1984 PLACE OF DEATH: WILMINGTON, DE.

CAUSE OF DEATH: HEART DISEASE (ICD-9 CODE: 410.9)

IMMEDIATE CAUSE: HEART DISEASE (ICD-9 CODE: 410.9)

UNDERLYING CAUSE: HEART DISEASE (ICD-9 CODE: 410.9)

DATE OF AUTOPSY: 1/13/1984 PLACE OF AUTOPSY: WILMINGTON, DE.

DATE OF BURIAL: 1/13/1984 PLACE OF BURIAL: WILMINGTON, DE.

DATE OF CREMATION: 1/13/1984 PLACE OF CREMATION: WILMINGTON, DE.

DATE OF INTERMENT: 1/13/1984 PLACE OF INTERMENT: WILMINGTON, DE.

DATE OF EXHUMATION: 1/13/1984 PLACE OF EXHUMATION: WILMINGTON, DE.

DATE OF REINTERMENT: 1/13/1984 PLACE OF REINTERMENT: WILMINGTON, DE.

DATE OF REINTERMENT: 1/13/1984 PLACE OF REINTERMENT: WILMINGTON, DE.

DATE OF REINTERMENT: 1/13/1984 PLACE OF REINTERMENT: WILMINGTON, DE.

DATE OF REINTERMENT: 1/13/1984 PLACE OF REINTERMENT: WILMINGTON, DE.

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.
TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon pages. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18

8036

CERTIFICATE OF DEATH

Reg. Dist. No.

08019

1. PLACE OF DEATH a. COUNTY Howard MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) o. STATE Maryland b. COUNTY Howard	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) (Rural) Ellicott City		c. LENGTH OF STAY IN 1b 43 yrs.	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION 24 Orchard Drive		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First MARGARET Middle ELEANOR Last MILLER		4. DATE OF DEATH Month 7 Day 25 Year 1959	
5. SEX Female	6. COLOR OR RACE White	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH Mar. 27, 1916
9. AGE (In years last birthday) 43 yrs.		IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) Clerk - Bookkeeper		10b. KIND OF BUSINESS OR INDUSTRY Retail Store	
11. BIRTHPLACE (State or foreign country) Maryland		12. CITIZEN OF WHAT COUNTRY? U. S. A.	
13. FATHER'S NAME Frank Otten		14. MOTHER'S MAIDEN NAME Nora Deutsch	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) No (If yes, give war or dates of service)		16. SOCIAL SECURITY NO. 215-05-9904	
INFORMANT A. R. Miller		Address 24 Orchard Dr. Ellicott City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Periphereal vascular collapse 199.2 DUE TO gastro-intestinal hemorrhage Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) Metastatic Carcinoma (c) Metastatic Carcinoma		INTERVAL BETWEEN ONSET AND DEATH 15 min 2 hrs. 1 yr.	
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)		19. WAS AUTOPSY PERFORMED? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. 19		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from July 24, 1959 , to July 25, 1959 , that I last saw the deceased alive on July 24, 1959 , and that death occurred at 7:35 P.M. from the causes and on the date stated above.			
ACTUAL SIGNATURE Thomas J. Herbert		ADDRESS (Street, city or town, state) Ellicott City, Md.	
PHYSICIAN'S NAME (Type) Ellicott City, Md.		DATE SIGNED 7-27-59	
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7/28/59	
22c. NAME OF CEMETERY OR CREMATORY Good Shepherd Cemetery		22d. LOCATION (City, town, or county) (State) Ellicott City, Md.	
23. FUNERAL DIRECTOR'S SIGNATURE Easton, Son		24a. REC'D BY REGISTRAR Catonsville, Md.	
24b. REGISTRAR'S SIGNATURE Jul 30 '59		24c. REGISTRAR'S SIGNATURE Arthur S. Kraus	

CERTIFICATE OF DEATH

0036

1910

1910

1910

(Name) (Address) (City) (State) (Country)

(Name) (Address) (City) (State) (Country)

(Name) (Address) (City) (State) (Country)

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TO DEPUTY MEDICAL EXAMINER: This certificate should be executed within 24 hours after death. If delay is necessary, please execute the certificate, writing the word "pending" in pencil in Item 18. Give Pages 1, 2, and 3 to the funeral director. Page 4 should be forwarded to the Chief Medical Examiner's Office along with form PM-3. Page 5 may be retained for your file. File pages 1 and 2 with the registrar to-burial, cremation, or removal.

VS. A15ME(5)
SM 9/55

8037 MARYLAND STATE DEPARTMENT OF HEALTH—BALTIMORE, 18
MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Reg. Dist. No. 08020

1. PLACE OF DEATH a. COUNTY Howard MARYLAND				2. USUAL RESIDENCE (Where deceased lived. If Institution: Residence before admission) a. STATE Maryland b. COUNTY Howard			
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City		c. LENGTH OF STAY IN 1b life		c. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) Ellicott City			
d. NAME OF HOSPITAL OR INSTITUTION (If not in hospital, give street address) Rogers Ave.				d. STREET ADDRESS Rogers Ave.		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Roy Middle L Last Radcliffe				4. DATE OF DEATH Month July Day 16 Year 1959			
5. SEX male		6. COLOR OR RACE white		7. MARRIED <input type="checkbox"/> NEVER MARRIED <input checked="" type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>		8. DATE OF BIRTH Oct. 16, 1891	
9. AGE (In years last birthday) 67 yrs.		IF UNDER 1 YEAR Months 67 Days 16 Hours 1959 Min.		10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) retired		10b. KIND OF BUSINESS OR INDUSTRY self employed	
11. BIRTHPLACE (State or foreign country) Maryland				12. CITIZEN OF WHAT COUNTRY? Maryland			
13. FATHER'S NAME Samuel E. Radcliffe				14. MOTHER'S MAIDEN NAME Adie E. Cassidy			
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) no		16. SOCIAL SECURITY NO. 217-09-8199		17. INFORMANT Miss Irene Radcliffe		Address Ellicott City, Md.	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) Coronary occlusion 420.1 DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause last. (b) 10 min. DUE TO (c)							
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)							
20a. EXTERNAL CAUSE WAS PRIMARY <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH.				20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Hour 19 a. m. 19 p. m.		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I took charge of the remains described above, held an Autopsy <input type="checkbox"/> . Inspection <input checked="" type="checkbox"/> . Inquiry <input checked="" type="checkbox"/> and find that death resulted from: Natural causes <input checked="" type="checkbox"/> . Accident <input type="checkbox"/> . Suicide <input type="checkbox"/> . Homicide <input type="checkbox"/> . Undetermined cause <input type="checkbox"/> .							
ACTUAL SIGNATURE Thomas F. Herbert				CHIEF MEDICAL EXAMINER <input type="checkbox"/>			
EXAMINER'S NAME (Type) Thomas F. Herbert				ASSISTANT MEDICAL EXAMINER <input type="checkbox"/>			
				DEPUTY MEDICAL EXAMINER <input checked="" type="checkbox"/>			
22a. BURIAL, CREMATION, REMOVAL (Specify) Burial		22b. DATE THEREOF 7-20-59		22c. NAME OF CEMETERY OR CREMATORY St Johns		22d. LOCATION (City, town, or county) (State) Ellicott City Md	
23. FUNERAL DIRECTOR'S SIGNATURE F.E. Higginbotham				ADDRESS Ellicott City, Md.		24a. REC'D BY REGISTRAR JUL 20 '59	
				24b. REGISTRAR'S SIGNATURE Arthur S. Haines			

2007 MEDICAL EXAMINER'S CERTIFICATE OF DEATH

Name of Deceased		Sex		Age	
John Doe		Male		45	
Residence		Occupation		Cause of Death	
123 Main St, Baltimore, MD		Teacher		Heart Disease	
Date of Death		Time of Death		Place of Death	
Jan 15, 1958		10:30 AM		Home	
Physician		Medical Examiner		Hospital	
Dr. Smith		Dr. Jones		St. Mary's	
Signature		Signature		Signature	
[Signature]		[Signature]		[Signature]	
Witness		Witness		Witness	
[Signature]		[Signature]		[Signature]	
Coroner		Coroner		Coroner	
[Signature]		[Signature]		[Signature]	

8038

CERTIFICATE OF DEATH

Reg. Dist. No. 08021

1. PLACE OF DEATH a. COUNTY <u>HOWARD</u> MARYLAND		2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>MARYLAND</u> b. COUNTY <u>HOWARD</u>	
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>ELICOTT CITY</u>		c. LENGTH OF STAY IN 1b	
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>DAVIS Rd</u>		e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>	
3. NAME OF DECEASED (Type or print) First Middle Last <u>John Henderson Sinclair Jr</u>		4. DATE OF DEATH Month Day Year <u>July 18 1959</u>	
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>JUNE 15 1902</u>
9. AGE (In years last birthday) <u>57</u> yrs.		10. IF UNDER 1 YEAR Months Days Hours Min.	
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>CARE TAKER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>ANIMAL SHELTER</u>	
11. BIRTHPLACE (State or foreign country) <u>SCOTLAND</u>		12. CITIZEN OF WHAT COUNTRY? <u>GREAT BRITAIN</u>	
13. FATHER'S NAME <u>John H. Sinclair Sr</u>		14. MOTHER'S MAIDEN NAME <u>Elizabeth Horne</u>	
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>579-54-0908</u>	
17. INFORMANT <u>Mrs Catherine Sinclair</u>		Address <u>DAVIS Rd. ELICOTT CITY</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>MYOCARDIAL INFARCTION</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the underlying cause lost. (b) <u>CORONARY THROMBOSIS</u> (c) <u>Arteriosclerotic Cardiovascular disease?</u> PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH, BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a)			INTERVAL BETWEEN ONSET AND DEATH <u>3 wks</u> <u>3 wks</u>
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)	
20c. TIME OF INJURY Month, Day, Year Hour a. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>	
20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.)		20f. (City or town) (County) (State)	
21. I certify that I attended the deceased from <u>6-24</u> , 19 <u>59</u> , to <u>7-18</u> , 19 <u>59</u> , that I last saw the deceased alive on <u>7-17</u> , 19 <u>59</u> , and that death occurred at <u>3 PM</u> , from the causes and on the date stated above.			
ACTUAL SIGNATURE <u>P. Thorpe</u>		ADDRESS (Street, city or town, state) <u>COLUMBIA RD</u>	
PHYSICIAN'S NAME (Type) <u>PETER V. THORPE, MD</u>		DATE SIGNED <u>7-20-59</u>	
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>CREMATION</u>		22b. DATE THEREOF <u>7-24-59</u>	
22c. NAME OF CEMETERY OR CREMATORY <u>LODON PARK</u>		22d. LOCATION (City, town, or county) (State) <u>Baltimore Md</u>	
23. FUNERAL DIRECTOR'S SIGNATURE <u>F.C. Higginbotham</u>		24a. REC'D BY REGISTRAR <u>DATE JUL 27 '59</u>	
ADDRESS <u>ELICOTT CITY, MD</u>		24b. REGISTRAR'S SIGNATURE <u>Arthur L. Krause</u>	

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

1911

CERTIFICATE OF DEATH

8038

[Faint, mostly illegible text, likely a death certificate form with fields for name, age, date, and cause of death.]

8039

CERTIFICATE OF DEATH

Reg. Dist. No.

08022

1. PLACE OF DEATH o. COUNTY <u>Howard</u> MARYLAND			2. USUAL RESIDENCE (Where deceased lived. If institution: Residence before admission) a. STATE <u>Maryland</u> b. COUNTY <u>Howard</u>		
b. CITY OR TOWN (If outside corporate limits, write RURAL and give nearest town) <u>Highland</u>			c. LENGTH OF STAY IN 1b <u>X Highland</u>		
d. NAME OF HOSPITAL (If not in hospital, give street address) OR INSTITUTION <u>RURAL</u>			e. IS RESIDENCE ON A FARM? YES <input type="checkbox"/> NO <input checked="" type="checkbox"/>		
3. NAME OF DECEASED (Type or print) First <u>Isaac</u> Middle <u>Amos</u> Last <u>Smith</u>			4. DATE OF DEATH Month <u>July</u> Day <u>23</u> Year <u>1959</u>		
5. SEX <u>MALE</u>	6. COLOR OR RACE <u>WHITE</u>	7. MARRIED <input checked="" type="checkbox"/> NEVER MARRIED <input type="checkbox"/> WIDOWED <input type="checkbox"/> DIVORCED <input type="checkbox"/>	8. DATE OF BIRTH <u>FEB 9 1987</u>	9. AGE (In years last birthday) <u>72</u> yrs.	IF UNDER 1 YEAR Months Days Hours Min.
10a. USUAL OCCUPATION (Give kind of work done during most of working life, even if retired) <u>POSTMASTER</u>		10b. KIND OF BUSINESS OR INDUSTRY <u>RETIRED</u>		11. BIRTHPLACE (State or foreign country) <u>West Virginia</u>	
12. CITIZEN OF WHAT COUNTRY?					
13. FATHER'S NAME <u>HENRY CLAY SMITH</u>			14. MOTHER'S MAIDEN NAME <u>SARAH F. AMOS</u>		
15. WAS DECEASED EVER IN U. S. ARMED FORCES? (Yes, no, or unknown) <u>No</u>		16. SOCIAL SECURITY NO. <u>214-32-9751</u>		INFORMANT <u>Mrs MARY E. SMITH Highland, Md</u>	
18. CAUSE OF DEATH [Enter only one cause per line for (a), (b), and (c).] PART I. DEATH WAS CAUSED BY: IMMEDIATE CAUSE (a) <u>ACUTE CARDIAC FAILURE</u> <u>420.1</u> DUE TO Conditions, if any, which gave rise to immediate cause (a), stating the <u>under-</u> lying cause last. (b) <u>CORONARY ARTERY OCCLUSION</u> DUE TO (c) <u>INSTANT</u>					INTERVAL BETWEEN ONSET AND DEATH <u>INSTANT</u>
PART II. OTHER SIGNIFICANT CONDITIONS CONTRIBUTING TO DEATH BUT NOT RELATED TO THE TERMINAL DISEASE CONDITION GIVEN IN PART I (a) <u>CHRONIC BRONCHITIS & BRONCHIECTASIS</u>					
20a. ACCIDENT WAS UNDERLYING <input type="checkbox"/> OR CONTRIBUTING <input type="checkbox"/> CAUSE OF DEATH (IF EITHER, NOTIFY MEDICAL EXAMINER)		20b. DESCRIBE HOW INJURY OCCURRED. (Enter nature of injury in Part I or Part II of item 18.)			
20c. TIME OF INJURY Month, Day, Year Hour o. m. p. m. <u>19</u>		20d. INJURY OCCURRED While at work <input type="checkbox"/> Not while at work <input type="checkbox"/>		20e. PLACE OF INJURY (Home, farm, factory, street, office bldg., etc.) <u>CLARKSVILLE, MD</u>	
20f. (City or town) <u>CLARKSVILLE, MD</u>		(County) (State)			
21. I certify that I attended the deceased from <u>JULY 23, 1959</u> to <u>JULY 29, 1959</u> that I last saw the deceased alive on <u>JULY 23, 1959</u> , and that death occurred at <u>7:15 P</u> M, from the causes and on the date stated above. ADDRESS (Street, city or town, state) DATE SIGNED					
ACTUAL SIGNATURE <u>Charles S. Whitaker</u> M.D.					
PHYSICIAN'S NAME (Type) <u>CHARLES S. WHITAKER, M.D. CLARKSVILLE, MD 7/24/59</u>					
22a. BURIAL, CREMATION, REMOVAL (Specify) <u>BURIAL</u>		22b. DATE THEREOF <u>7-27-59</u>		22c. NAME OF CEMETERY OR CREMATORY <u>WOODSIDE CEM.</u>	
22d. LOCATION (City, town, or county) <u>BRICKLAW</u>		(State)			
23. FUNERAL DIRECTOR'S SIGNATURE <u>F. C. Higginbotham</u>		ADDRESS <u>ELLIOTT CITY, MD.</u>		24a. REC'D BY REGISTRAR DATE <u>JUL 30 '59</u>	
24b. REGISTRAR'S SIGNATURE <u>Arthur S. Hume</u>					

1

TO HOSPITAL OR ATTENDING PHYSICIAN: The law requires that the death certificate be executed within 24 hours after death. Page 4 may be retained by the hospital or attending physician.

TO FUNERAL DIRECTOR: After this certificate has been signed by the attending physician and completely filled in, the funeral director, page 3 should be detached for use as the burial-transit permit. Then please remove carbon papers. Pages 1 and 2 should be filed with the registrar prior to burial, cremation, or removal, and in any event within 72 hours after death.

VS A15 (4)
15M 9/58

